



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALFREDO RODRIGUEZ
3141 IRVING BLVD STE 220A
DALLAS, TX 75247

Respondent Name

INDEMNITY INSURANCE CO OF NORT

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-13-1515-01

MFDR Date Received

February 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As per your EOB it appears that the payment has an outstanding balance of \$650. As outlined in DWC Rule 130.204(i) and DWC Rules and Regulations, we are to bill out according to the Medical Fee Guidelines for Workers' Compensation Specific Services ... Please note that at this time there is an outstanding balance of \$650."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No insurance carrier response received

Response Submitted by: N/A

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| July 23, 2012 | 99456 W5 RE | \$650.00 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 *Texas Register* 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 21, 2012

- 29 – The time limit for filing has expired

Issues

1. Was the bill submitted timely to the insurance carrier?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied...” Review of the documentation submitted by the requestor finds no convincing evidence to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

Denial code “29 – The time limit for filing has expired” is not supported.

2. Requestor billed with CPT Code 99456 W5 WP for a Maximum Medical Improvement (MMI) and Impairment Rating evaluation with one unit billed in the amount of \$650.00.

Review of the submitted documentation supports that a Request for Designated Doctor Examination was requested to address Maximum Medical Improvement (MMI) and Impairment Rating (IR) with one body area being rated using range of motion (ROM) method.

Per Administrative Code §134.204 (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350, (4) The following applies for billing and reimbursement of an IR evaluation, (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas, (i) Musculoskeletal body areas are defined as follows, (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet), (ii) The MAR for musculoskeletal body areas shall be as follows, (II) If full physical evaluation, with range of motion, is performed, (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area.

Therefore CPT Code 99456 W5 WP is supported. The total Mar is \$650.00.

3. The respondent issued payment in the amount of \$0.00. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

| | | |
|-----------|--|---------|
| _____ | _____ | 9/13/13 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.